		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023242

Facility Name: Rest Haven South Nursing Home

Address: 16300 Wausau (Number) South Holland (City) 60473 (Zip Code)

County: Cook

Telephone Number: (708) 596-5500 **Fax #** (708) 877-4827

IDPA ID Number: 3623828530001

Date of Initial License for Current Owners: 02/02/1977

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,586	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,586	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,240	28,636	7,678	51,554	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,240	28,636	7,678	51,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.37%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/02/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 7,678

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	363,448	50,668	12,000	426,116		426,116		426,116			1
2	Food Purchase		303,711		303,711		303,711	(14,606)	289,105			2
3	Housekeeping	176,879	41,367		218,246		218,246		218,246			3
4	Laundry	110,163	20,131		130,294		130,294	(14,650)	115,644			4
5	Heat and Other Utilities			150,619	150,619		150,619	10,112	160,731			5
6	Maintenance	219,056		123,831	342,887		342,887	(10,631)	332,256			6
7	Other (specify):*											7
8	**TOTAL General Services**	869,546	415,877	286,450	1,571,873		1,571,873	(29,775)	1,542,098			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,275,077	483,815	256,739	4,015,631		4,015,631		4,015,631			10
10a	Therapy		1,713	577,233	578,946		578,946		578,946			10a
11	Activities	120,764	15,024		135,788		135,788		135,788			11
12	Social Services	46,799	476	3,990	51,265		51,265		51,265			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,442,640	501,028	849,962	4,793,630		4,793,630		4,793,630			16
	C. General Administration											
17	Administrative			846,000	846,000		846,000	(757,123)	88,877			17
18	Directors Fees											18
19	Professional Services			34,498	34,498		34,498	9,794	44,292			19
20	Dues, Fees, Subscriptions & Promotions			28,235	28,235		28,235	11,318	39,553			20
21	Clerical & General Office Expenses	227,932	31,994	46,266	306,192		306,192	385,878	692,070			21
22	Employee Benefits & Payroll Taxes			1,039,175	1,039,175		1,039,175		1,039,175			22
23	Inservice Training & Education							247	247			23
24	Travel and Seminar			6,881	6,881		6,881	16,112	22,993			24
25	Other Admin. Staff Transportation							1,695	1,695			25
26	Insurance-Prop.Liab.Malpractice			178,351	178,351		178,351	10,786	189,137			26
27	Other (specify):* **Allocated Benefits**							95,309	95,309			27
28	**TOTAL General Administration**	227,932	31,994	2,179,406	2,439,332		2,439,332	(225,984)	2,213,348			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,540,118	948,899	3,315,818	8,804,835		8,804,835	(255,759)	8,549,076			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rest Haven South Nursing Home #0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			456,227	456,227		456,227	9,055	465,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,552	206,552		206,552	(62,523)	144,029			32
33	Real Estate Taxes							7,351	7,351			33
34	Rent-Facility & Grounds							1,269	1,269			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			662,779	662,779		662,779	(44,848)	617,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		647,831		647,831		647,831		647,831			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,392	94,392		94,392		94,392			42
43	Other (specify):* Nonallowable Costs			339,645	339,645		339,645	(339,645)				43
44	**TOTAL Special Cost Centers**		647,831	434,037	1,081,868		1,081,868	(339,645)	742,223			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,540,118	1,596,730	4,412,634	10,549,482		10,549,482	(640,252)	9,909,230			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,018)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(14,650)	4		8
9	Non-Straightline Depreciation	(70,750)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(96,790)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(150,000)	43		24
25	Fund Raising, Advertising and Promotional	(65,978)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,988)	43		28
29	Other-Attach Schedule See Sch 5A	(131,928)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (559,102)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(81,150)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (81,150)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (640,252)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Nursing Home
Provider #: 0023242
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Deferred maintenance expense	1,436	6
To record additional LSN dues	1,931	20
Offset postage income	(84)	21
Offset beauty and barber income	(24,131)	21
Offset miscellaneous income	(1,401)	21
Disallow lab expense	(34,637)	43
Disallow physiatry expense	(69,525)	43
Disallow resident welfare	(5,517)	43
Total	(131,928)	

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Nursing Home

ID# 0023242

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven South Nursing Home **#** 0023242 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,018)	412	0	0	0	0	0	0	0	0	0	(14,606)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(14,650)	0	0	0	0	0	0	0	0	0	0	(14,650)	4
5	Heat and Other Utilities	0	10,112	0	0	0	0	0	0	0	0	0	10,112	5
6	Maintenance	0	(12,067)	0	0	0	0	0	0	0	0	0	(12,067)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29,668)	(1,543)	0	0	0	0	0	0	0	0	0	(31,211)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(757,123)	0	0	0	0	0	0	0	0	0	(757,123)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,794	0	0	0	0	0	0	0	0	0	9,794	19
20	Fees, Subscriptions & Promotions	0	9,387	0	0	0	0	0	0	0	0	0	9,387	20
21	Clerical & General Office Expenses	0	411,494	0	0	0	0	0	0	0	0	0	411,494	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	247	0	0	0	0	0	0	0	0	0	247	23
24	Travel and Seminar	0	16,112	0	0	0	0	0	0	0	0	0	16,112	24
25	Other Admin. Staff Transportation	0	1,695	0	0	0	0	0	0	0	0	0	1,695	25
26	Insurance-Prop.Liab.Malpractice	0	10,786	0	0	0	0	0	0	0	0	0	10,786	26
27	Other (specify):*	0	95,309	0	0	0	0	0	0	0	0	0	95,309	27
28	**TOTAL General Administration**	0	(202,299)	0	0	0	0	0	0	0	0	0	(202,299)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,668)	(203,842)	0	0	0	0	0	0	0	0	0	(233,510)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(70,750)	79,805	0	0	0	0	0	0	0	0	0	9,055	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96,790)	0	34,267	0	0	0	0	0	0	0	0	(62,523)	32
33	Real Estate Taxes	0	0	7,351	0	0	0	0	0	0	0	0	7,351	33
34	Rent-Facility & Grounds	0	0	1,269	0	0	0	0	0	0	0	0	1,269	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(167,540)	79,805	42,887	0	0	0	0	0	0	0	0	(44,848)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(229,966)	0	0	0	0	0	0	0	0	0	0	(229,966)	43
44	**TOTAL Special Cost Centers**	(229,966)	0	0	0	0	0	0	0	0	0	0	(229,966)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(427,174)	(124,037)	42,887	0	0	0	0	0	0	0	0	(508,324)	45

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home	100	Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
		Rest Haven West	Downers Grove	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	Tinley Park	Management Co.
				Providence Home Health Care	Tinley Park	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 412	$ 412	1
2	V	5	Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	10,112	10,112	2
3	V	6	Maintenance	17,712	Rest Haven Illiana Christian Convalescent Home	100.00%	5,645	(12,067)	3
4	V	17	Administrative	846,000	Rest Haven Illiana Christian Convalescent Home	100.00%	88,877	(757,123)	4
5	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	9,794	9,794	5
6	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	9,387	9,387	6
7	V	21	Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	411,494	411,494	7
8	V	23	Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	247	247	8
9	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	16,112	16,112	9
10	V	25	Other admin. staff transport.		Rest Haven Illiana Christian Convalescent Home	100.00%	1,695	1,695	10
11	V	26	Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	10,786	10,786	11
12	V	27	Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	95,309	95,309	12
13	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	79,805	79,805	13
14	Total			$ 863,712			$ 739,675	$ * (124,037)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 34,267	$ 34,267	15
16	V	33	Real estate taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	7,351	7,351	16
17	V	34	Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	1,269	1,269	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 42,887	$ * 42,887	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5					N/A - Voluntary Board with no compensation. See attached Schedule 7A						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated cost	70,996,213	15	$ 3,030	$	9,654,045	$ 412	1
2	5	Utilities	Accumulated cost	70,996,213	15	74,367		9,654,045	10,112	2
3	6	Maintenance	Accumulated cost	70,996,213	15	41,515		9,654,045	5,645	3
4	19	Professional services	Accumulated cost	70,996,213	15	72,028		9,654,045	9,794	4
5	20	Dues, fees & subscriptions	Accumulated cost	70,996,213	15	69,035		9,654,045	9,387	5
6	21	Clerical & gen. office - salary	Accumulated cost	70,996,213	15	2,699,260	2,699,260	9,654,045	367,045	6
7	21	Clerical & gen. office	Accumulated cost	70,996,213	15	326,877		9,654,045	44,449	7
8	23	Inservice training & education	Accumulated cost	70,996,213	15	1,814		9,654,045	247	8
9	24	Travel & seminar	Accumulated cost	70,996,213	15	118,491		9,654,045	16,112	9
10	25	Other admin. staff transport.	Accumulated cost	70,996,213	15	12,467		9,654,045	1,695	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	70,996,213	15	79,324		9,654,045	10,786	11
12	27	Mgmt. allocation of benefits	Accumulated cost	70,996,213	15	700,904		9,654,045	95,309	12
13	30	Depreciation	Accumulated cost	70,996,213	15	586,888		9,654,045	79,805	13
14	32	Interest	Accumulated cost	70,996,213	15	252,004		9,654,045	34,267	14
15	33	Real estate taxes	Accumulated cost	70,996,213	15	54,062		9,654,045	7,351	15
16	34	Rent - facility & grounds	Accumulated cost	70,996,213	15	9,329		9,654,045	1,269	16
17										17
18	17	Administrative	Direct cost			720,689	720,689		88,877	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,822,084	$ 3,419,949		$ 782,562	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Individual Notes		X	Building Improvements	Varies	Varies	$ 70,321	$ 8,321	Varies	Varies	$ 2,570	1
2	Tax Exempt Bonds		X	Building	Varies	11/1/04	4,200,000	4,200,000	10/31/34	Varies	12,291	2
3	Tax Exempt Bonds		X	Building	Varies	2/26/97	2,633,850		2/26/97	Varies	191,691	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,904,171	$ 4,208,321			$ 206,552	9
	B. Non-Facility Related*											
10								Disallow non-care interest			(96,790)	10
11								Allocated from Home Office			34,267	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (62,523)	14
15	TOTALS (line 9+line14)						$ 6,904,171	$ 4,208,321			$ 144,029	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Allocated from Home Office**		$ 7,351	6
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,351	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

Real estate taxes are allocated from a for-profit management entity.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven South Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023242

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 342-8100 FAX #: (708) 342-8006

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-01-203-003-0000	New Home Office Building	$ 54,062.00	$ 7,351.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,062.00	$ 7,351.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO **See Page 8 for Allocation**

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills** **Real estate taxes are accrued, bill has not yet been received on the new buildin**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	Not available	1976	$ 31,305	1
2					2
3	TOTALS			$ 31,305	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1977	1977	$ 2,657,266	$ 66,432	40	$ 66,432	$	$ 1,790,975	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping Improvements			1977	19,723		20			19,723	9
10	Building Improvements			1978	7,401		40	185	185	3,004	10
11	Land Improvements			1981	2,535		20			2,535	11
12	Building Improvements			1982	8,179		40	204	204	4,513	12
13	Building Improvements			1983	4,035		40	101	101	2,131	13
14	Land Improvements			1984	7,625	310	20	310		7,625	14
15	Building Improvements			1985	2,029		40	51	51	974	15
16	Building Improvements			1986	49,092		40	1,227	1,227	22,317	16
17	Building Improvements			1987	48,670		40	1,217	1,217	20,943	17
18	Land Improvements			1987	4,898	245	20	245		4,226	18
19	Building Improvements			1988	21,602	1,428	40	540	(888)	8,768	19
20	Land Improvements			1988	1,600	80	20	80		1,302	20
21	Building Improvements			1898	561,415	14,035	40	14,035		214,195	21
22	Land Improvements			1898	9,437	472	20	472		7,218	22
23	Building Improvements			1990	98,412	6,561	40	2,460	(4,101)	35,148	23
24	Building Improvements			1991	74,357	4,957	40	1,859	(3,098)	24,746	24
25	Building Improvements			1992	168,370	4,209	40	4,209		51,926	25
26	Land Improvements			1992	13,785	689	20	689		8,518	26
27	Building Improvements			1994	24,717	1,648	40	618	(1,030)	6,419	27
28	Building Improvements			1995	52,042	3,469	40	1,301	(2,168)	12,359	28
29	Land Improvements			1995	10,722	536	20	536		5,092	29
30	Landscaping			1996	20,214	1,347	20	1,010	(337)	8,283	30
31	Building Redecorating			1996	15,578	1,039	40	390	(649)	3,455	31
32	Building Improvement - Ceiling			1996	25,000	1,667	40	625	(1,042)	5,052	32
33	Building Improvements - HVAC			1996	5,000		40	125	125	1,010	33
34	Landscaping			1997	27,690	1,846	20	1,349	(497)	10,293	34
35	Building Resident Room Redecorating			1997	64,348	4,290	40	1,609	(2,681)	11,874	35
36	Building - Ceiling & Lighting			1997	62,447	3,663	40	1,561	(2,102)	12,135	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Fire Alarm System	1997	$ 4,483	$ 640	40	$ 112	$ (528)	$ 877	37
38	Building - HVAC	1997	43,720	2,915	40	1,093	(1,822)	8,471	38
39	Building Improvement Resident Rooms in Gilead Area	1997	44,208	2,947	40	1,105	(1,842)	7,797	39
40	Building - Elevator Repair	1997	12,780	852	40	320	(532)	2,473	40
41	Building - Beauty Shop Renovation	1997	1,800	120	40	45	(75)	323	41
42	Land Improvement - Parking Lot	1998	46,302	2,315	20	2,316	1	15,054	42
43	Building Improvement Resident Rooms in Gilead Area	1998	34,374	2,338	40	859	(1,479)	5,584	43
44	Building - HVAC	1998	40,850	2,723	40	1,021	(1,702)	6,637	44
45	Building Rehab. Area	1998	68,738	4,455	40	1,718	(2,737)	11,167	45
46	Building - Kitchen Fan	1999	1,400	93	40	35	(58)	193	46
47	Building Therapy Room Renovation	1999	2,083	139	40	52	(87)	286	47
48	Building Improvement HVAC	2000	801,268	54,236	40	20,032	(34,204)	100,160	48
49	Building Improvement Social Service Office	2000	1,683	240	7	240		1,080	49
50	Land Improvement - Lighting	2000	30,000	2,000	15	2,000		9,000	50
51	Land Improvement - Fencing	2000	8,071	538	15	538		2,421	51
52	Building Improvement HVAC	2000	663,243	43,915	40	16,581	(27,334)	74,615	52
53	Building - Garage	2000	3,820	382	20	191	(191)	860	53
54	Building Improvement - Pipe Enclosure	2000	82,716	11,817	40	2,068	(9,749)	9,306	54
55	Building Improvement - Tile in Kitchen place into service 2001	2001	6,800	971	7	971		3,884	55
56	Land Improvement - Light Poles	2001	1,878		15	125	125	437	56
57	Building Improvements - HVAC	2001	19,808	822	40	495	(327)	1,733	57
58	Building Improvements - Kitchen Floor	2001	35,884	2,392	15	2,392		8,372	58
59	Building Improvements - Fire Protection System	2001	16,000	1,067	15	1,067		3,734	59
60	Building Improvements - Code Alert	2002	12,767	638	10	1,276	638	3,190	60
61	Building Improvements - Renovations- plumbing work	2002	4,712	157	15	314	157	785	61
62	Building Improvements - Renovations-plumbing and heating	2002	3,275	41	40	82	41	205	62
63	Building Improvements - painting, flooring, wallcoverings	2002	434,395	16,076	7	32,152	16,076	80,380	63
64	Building Improvements- walls, electrical,lighting	2002	431,434	3,103	40	6,206	3,103	15,515	64
65	Builiding Improvements- HVAC	2002	17,600	440	40	920	480	2,300	65
66	BI-Fire dampers	2003	62,407	4,161	15	4,161		6,241	66
67	BI-Door panels	2003	6,193	620	10	620		930	67
68	BI-Ceiling project	2003	21,725	543	40	543		815	68
69	BI-Alarm system	2003	35,502	1,775	20	1,775		2,663	69
70	TOTAL (lines 4 thru 69)		$ 7,070,108	$ 284,394		$ 206,865	$ (77,529)	$ 2,694,247	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,070,108	$ 284,394		$ 206,865	$ (77,529)	$ 2,694,247	1
2	LI-Heated sidewalk	2003	32,012	2,134	15	2,134		3,201	2
3	LI-Sign	2003	784	78	10	78		117	3
4	BI-Thermostats, heaters, pump motor, valves	2003	10,902	545	20	545		817	4
5	BI-Gate	2003	3,050	153	20	153		229	5
6	BI-Dental office	2004	15,500	194	40	194		194	6
7	BI-Alarm system	2004	2,860	204	7	204		204	7
8	BI-Fire protection system	2004	3,500	175	10	175		175	8
9	BI-Activity room	2004	967	69	7	69		69	9
10	BI-Fire protection cabinet	2004	2,850	204	7	204		204	10
11									11
12									12
13									13
14	Allocated from Home Office		565,329			14,123	14,123	36,835	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,707,862	$ 288,150		$ 224,744	$ (63,406)	$ 2,736,292	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,766,092	$ 166,551	$ 173,330	$ 6,779	3-10 yrs	$ 1,110,966	71
72	Current Year Purchases	36,272	1,526	1,526		5-15 yrs	1,526	72
73	Fully Depreciated Assets	1,508,733					1,508,733	73
74	Allocated from Home Office	491,671		63,969	63,969		259,264	74
75	TOTALS	$ 3,802,768	$ 168,077	$ 238,825	$ 70,748		$ 2,880,489	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Allocated from Home Office			22,999		1,713	1,713		4,801	77
78										78
79										79
80	TOTALS			$ 22,999	$	$ 1,713	$ 1,713		$ 4,801	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,564,934	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 456,227	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 465,282	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,055	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,621,582	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				1,269			6
7	TOTAL				$ 1,269 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 0 Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	4,386	$ 233,987	$	4,386	$ 233,987	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		647	63,604		647	63,604	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 2 & 3	hrs		4,661	279,642	1,713	4,661	281,355	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				647,831		647,831	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	9,694	$ 577,233	$ 649,544	9,694	$ 1,226,777	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,217	$ 1,217	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 289,941)	1,246,003	1,246,003	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,488	8,488	7
8	Accounts Receivable (owners or related parties)	7,565,023	11,765,023	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,820,731	$ 13,020,731	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,305	31,305	13
14	Buildings, at Historical Cost	7,089,360	7,707,862	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,345,200	3,825,767	16
17	Accumulated Depreciation (book methods)	(5,991,230)	(5,621,582)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,474,635	$ 5,943,352	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,295,366	$ 18,964,083	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 563,575	$ 563,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,706	9,706	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,424	151,424	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,845	5,845	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,918	2,918	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	38,491	38,491	36
37	Due to Related Parties	4,710,691	4,710,691	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,482,650	$ 5,482,650	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,321	8,321	39
40	Mortgage Payable			40
41	Bonds Payable		4,200,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,321	$ 4,208,321	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,490,971	$ 9,690,971	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,804,395	$ 9,273,112	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,295,366	$ 18,964,083	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name **Rest Haven South Christian Nursing Home**
PROVIDER # **0023242**
Period Ending **12/31/2004**

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	**Operating**	**After Consolidation**
Resident Gifts	2,350	2,350
TDA W/H - South	36,141	36,141
Total	**38,491**	**38,491**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,882,038	1
2	Restatements (describe):		2
3	**Prior period adjustment**	271,549	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,153,587	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(349,192)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (349,192)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,804,395	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,709,865	1
2	Discounts and Allowances for all Levels	(4,200,887)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,508,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	491,372	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 491,372	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	718,095	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,127	19
20	Radiology and X-Ray	34,983	20
21	Other Medical Services	352,451	21
22	Laundry	14,650	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,159,306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,401	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,401	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	39,233	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,233	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,200,290	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,571,873	31
32	Health Care	4,793,630	32
33	General Administration	2,439,332	33
	B. Capital Expense		
34	Ownership	662,779	34
	C. Ancillary Expense		
35	Special Cost Centers	987,476	35
36	Provider Participation Fee	94,392	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,549,482	40
41	**Income before Income Taxes (line 30 minus line 40)****	(349,192)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (349,192)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Rest Haven South Christian Nursing Home
Provider #: 0023242
12/31/2004

Schedule 19A

XVII. INCOME STATEMENT
Revenue - Line 28a

E. Other Revenue (specify):	Amount
Beauty/Barber	24,131
Postage Revenue	84
Meals	15,018
	39,233

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,080	$ 64,676	$ 31.09	1
2	Assistant Director of Nursing	1,712	1,720	47,838	27.81	2
3	Registered Nurses	25,459	27,093	683,626	25.23	3
4	Licensed Practical Nurses	28,103	30,934	630,186	20.37	4
5	Nurse Aides & Orderlies	133,653	143,424	1,758,176	12.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,014	2,272	39,852	17.54	9
10	Activity Assistants	5,741	6,367	80,912	12.71	10
11	Social Service Workers	3,003	3,323	46,799	14.08	11
12	Dietician	160	160	2,692	16.83	12
13	Food Service Supervisor	864	925	18,725	20.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,138	31,722	342,031	10.78	15
16	Dishwashers					16
17	Maintenance Workers	15,865	16,994	219,056	12.89	17
18	Housekeepers	13,262	14,457	176,879	12.23	18
19	Laundry	9,981	10,402	110,163	10.59	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,472	15,670	227,932	14.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,969	2,089	27,408	13.12	31
32	Other Health Ca Case Manager	2,064	2,080	63,167	30.37	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	291,524	311,712	$ 4,540,118 *	$ 14.57	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 12,000	L 1, C 3	35
36	Medical Director	Monthly	12,000	L 9, C 3	36
37	Medical Records Consultant	Monthly	4,128	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,684	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	2,520	L 12, C 3	45
46	Other(specify) Chapel Ministry	Monthly	1,470	L 12, C 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 39,802		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,474	$ 70,550	L 10, C 3	50
51	Licensed Practical Nurses	3,605	149,055	L 10, C 3	51
52	Nurse Aides	1,120	25,322	L 10, C 3	52
53	TOTAL (lines 50 - 52)	6,199	$ 244,927		53

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Van Drunen	Administrator	0	$ 88,877
Amount paid out of Home Office allocated in column 7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,877

B. Administrative - Other

Description	Amount
	$
Management Fees (Eliminated in Column 7)	846,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 846,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Myers, Miller & Krauskopf	Legal	$ 7,495
Laner, Muchin, Dambrow, Becker		
Levin and Tominberg Ltd.	Legal	12,027
Providence Management &		
Development Company Inc.	Consulting	185
KPMG	Accounting	4,400
Altschuler, Melvoin & Glasser	Accounting	7,416
American Express Tax &		
Business Services	Accounting	2,975
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,300
Unemployment Compensation Insurance	58,631
FICA Taxes	330,704
Employee Health Insurance	433,910
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension	71,690
Employee Welfare	18,588
Other Employee Benefits	16,352
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,039,175

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,888
Health Care Worker Background Check	
(Indicate # of checks performed 64)	544
Life Services Network of Illinois	14,938
JAHCO	7,339
Miscellaneous Licenses	2,631
Miscellaneous Subscriptions	380
Allocated from Home Office	8,843
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,553

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,568
Seminar Expense	5,313
Allocated from Home Office	16,112
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,993

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven South Nursing Home
Provider #: 0023242
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	34,498
Allocated from Management Company - Legal Fees	1,327
Allocated from Management Company - Other	8,467
Total (agree to Schedule V, line 19, column 8)	44,292

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Repair to Heater	Apr 2001	$ 4,792		$ 799	$ 1,597	$ 1,597	$ 799	$	$	$	$	$
2	Repair to Fan Motors	June 2001	1,537		256	512	512	257					
3	Repair Fire Alarm	Oct 2001	2,280		380	760	760	380					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,609		$ 1,435	$ 2,869	$ 2,869	$ 1,436	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven South Nursing Home # 0023242 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $14,938**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **149,780** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,392**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,018**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG-Peat Marwick LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	363,448	50,668	12,000	426,116	0	426,116	0	426,116
2. Food Purchase	0	303,711	0	303,711	0	303,711	-14,606	289,105
3. Housekeeping	176,879	41,367	0	218,246	0	218,246	0	218,246
4. Laundry	110,163	20,131	0	130,294	0	130,294	-14,650	115,644
5. Heat and Other Utilities	0	0	150,619	150,619	0	150,619	10,112	160,731
6. Maintenance	219,056	0	123,831	342,887	0	342,887	-10,631	332,256
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	869,546	415,877	286,450	1,571,873	0	1,571,873	-29,775	1,542,098
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	3,275,077	483,815	256,739	4,015,631	0	4,015,631	0	4,015,631
10a. Therapy	0	1,713	577,233	578,946	0	578,946	0	578,946
11. Activities	120,764	15,024	0	135,788	0	135,788	0	135,788
12. Social Services	46,799	476	3,990	51,265	0	51,265	0	51,265
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,442,640	501,028	849,962	4,793,630	0	4,793,630	0	4,793,630
17. Administrative	0	0	846,000	846,000	0	846,000	-757,123	88,877
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	34,498	34,498	0	34,498	9,794	44,292
20. Fees, Subscriptions & Promotion	0	0	28,235	28,235	0	28,235	11,318	39,553
21. Clerical & General Office	227,932	31,994	46,266	306,192	0	306,192	385,878	692,070
22. Employee Benefits & Payroll	0	0	1,039,175	1,039,175	0	1,039,175	0	1,039,175
23. Inservice Training & Education	0	0	0	0	0	0	247	247
24. Travel and Seminar	0	0	6,881	6,881	0	6,881	16,112	22,993
25. Other Admin. Staff Trans	0	0	0	0	0	0	1,695	1,695
26. Insurance-Prop.Liab.Malpractice	0	0	178,351	178,351	0	178,351	10,786	189,137
27. Other (specify)*	0	0	0	0	0	0	95,309	95,309
28. Total General Adminis	227,932	31,994	2,179,406	2,439,332	0	2,439,332	-225,984	2,213,348
29. Total General Administrative	4,540,118	948,899	3,315,818	8,804,835	0	8,804,835	-255,759	8,549,076
30. Depreciation	0	0	456,227	456,227	0	456,227	9,055	465,282
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	206,552	206,552	0	206,552	-62,523	144,029
33. Real Estate	0	0	0	0	0	0	7,351	7,351
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,269	1,269
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	662,779	662,779	0	662,779	-44,848	617,931
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	647,831	0	647,831	0	647,831	0	647,831
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	94,392	94,392	0	94,392	0	94,392
43. Other (specify):*	0	0	339,645	339,645	0	339,645	-339,645	0
44. Total Special Cost Ce	0	647,831	434,037	1,081,868	0	1,081,868	-339,645	742,223
45. Grand Total	4,540,118	1,596,730	4,412,634	10,549,482	0	10,549,482	-640,252	9,909,230

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,217	1,217
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,246,003	1,246,003
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	8,488	8,488
8. Accounts Receivable-Owner/Related Party	7,565,023	11,765,023
9. Other (specify):	0	0
10. Total current assets	8,820,731	13,020,731
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	31,305	31,305
14. Buildings, at Historical Cost	7,089,360	7,707,862
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,345,200	3,825,767
17. Accumulated Depreciation (book methods)	-5,991,230	-5,621,582
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	4,474,635	5,943,352
25. Total Assets	########	18,964,083
CURRENT LIABILITIES		
26. Accounts Payable	563,575	563,575
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	9,706	9,706
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	151,424	151,424
31. Accrued Taxes Payable	5,845	5,845
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	2,918	2,918
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	38,491	38,491
37. Other Current Liabilities (specify):	4,710,691	4,710,691
38. Total Current Liabilities	5,482,650	5,482,650
LONG TERM LIABILITES		
39.Long-Term Notes Payable	8,321	8,321
40.Mortgage Payable	0	0
41.Bonds Payable	0	4,200,000
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	8,321	4,208,321
46.Total Liabilities	5,490,971	9,690,971
47.Total Equity	7,804,395	9,273,112
48.Total Liabilities and Equity	########	18,964,083

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	12,709,865
2. Discounts and Allowances for all Levels	-4,200,887
Subtotal - Inpatient Care	8,508,978
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	491,372
7. Oxygen	0
Subtotal - Anciliary Revenue	491,372
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	718,095
18. Sale of Supplies to Non-Patients	0
19. Laboratory	39,127
20. Radiologyand X-Ray	34,983
21. Other Medical Services	352,451
22. Laundry	14,650
Subtotal - Other Operating Revenue	1,159,306
24. Contributions	0
25. Interest and Other Investments Income	1,401
Subtotal - Non-Operating Revenue	1,401
27. Other Revenue (specify):	0
28. Other Revenue (specify):	39,233
Subtotal - Other Revenue	39,233
30. Total Revenue	10,200,290
31. General Services	1,571,873
32. Health Care	4,793,630
33. General Administration	2,439,332
34. Ownership	662,779
35. Special Cost Centers	987,476
35. Provider Participation Fee	94,392
37. Other	0
40. Total Expenses	10,549,482
41. Income Before Income Taxes	-349,192
42. Income Taxes	0
43. Net Income or Loss for the Year	-349,192

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